SICKLE CELL NEWBORN SCREENING PROGRAM REQUEST FOR ASSISTANCE

State Form 44962 (R3 / 4-02)

Indiana State Department of Health

INDIANA STATE DEPARTMENT OF HEALTH
2 North Meridian Street, 7F
Indianapolis, IN 46204

CONFIDENTIAL INFORMATION

Date (*month, day, year*):	Name of county:

Please advise the parent(s) of the infant named below that a repeat test or initial test for newborn screening is necessary. This can be done at the hospital or any other facility that has the heel-stick test kit and whole blood test. The hospital of birth is preferable as generally there is no additional charge for a rescreen. If the parents have any questions regarding this request, they may contact the Sickle Cell Newborn Screening Program at the Indiana State Department of Health, (317) 233-7453.

INFANT NEEDS: (*all boxes checked apply*)

- ☐ Initial Heel-Stick Date completed: ____/____/____
- ☐ Transfused
- ☐ Rescreen at 8 weeks of age
- ☐ Premature

Weight at birth: ____lbs. ____ozs. Race: ____

Sex: ☐ Male ☐ Female

- ☐ 1st Repeat Whole Blood Date completed: ____/____/____
- ☐ 2nd Repeat Whole Blood Date completed: ____/____/____
- ☐ Initial Counseling Date completed: ____/____/____
- ☐ Abnormal Result ____ Date completed: ____/____/____
- ☐ Confirmed Result ____ Date completed: ____/____/____
- ☐ **Confirmed Counseling** **Date completed:** ____/____/____

Additional comments:

Return follow-up report by: ____/____/____ **Date of birth:** ____/____/____

NAME OF INFANT: ____

LAST (*at birth*) **LAST** (*if new name*) **FIRST** **MIDDLE** **HOSPITAL ID#**

Name of Requisition Physician ____ Birthing center: ____

Physician's address ____ Physician's telephone (____) ____

Name of mother ____ Date of birth: ____/____/____

LAST FIRST MIDDLE MAIDEN NAME

Mother's address ____ Telephone (____) ____

Name of father ____ Telephone (____) ____

Name of other ____ Telephone (____) ____

Has patient already received medical follow-up and counseling? ☐ Yes ☐ No

If Yes, where: ____ Name of Physician ____ Date ____

____ Name of Counselor ____ Date ____

Prophylactic Penicillin: ☐ Yes ☐ No ISDH Penicillin Program: ☐ Yes ☐ No

Name of Treatment Physician ____ Telephone (____) ____ Initial date of treatment ____/____/____

Treatment Physician's address: ____

Public Health Department / Sickle Cell Center Contacts:

Date contacted: Remarks (*persons contacted*)

1. Date contacted: ____/____/____ ____
2. Date contacted: ____/____/____ ____
3. Date contacted: ____/____/____ ____

☐ No such address ☐ Parents refused further testing ☐ Moved out of state ☐ Lost to follow-up

Will obtain screen at: ____

Signature of Ph.D./Sickle Cell Staff ____ Position: ____

Telephone (____) ____ Date center received: ____/____/____ Date center returned: ____/____/____

Additional comments:

Return to: White - ISDH; Canary - Sickle Cell Project